STATE OF ARKANSAS
DEPARTMENT OF FINANCE AND ADMINISTRATION

RESPONSE TO EMPLOYEE REQUEST FOR FAMILY OR MEDICAL LEAVE

Family and Medical Leave Act of 1993

Date: _____

To: _____
Employee's Name

_____ _____
Social Security Number Position Number

From: _____
Agency / Institution Name and Agency / Institution Official

Subject: **Request for Family/Medical Leave**

On _____, you notified us of your need to take family/medical leave due to:
(date)

❑ The birth of your child, or the placement of a child with you for adoption or foster care; or

❑ A serious health condition that makes you unable to perform the essential functions of your job; or

❑ A serious health condition affecting your ❑ spouse, ❑ child, ❑ parent, for which you are needed to provide care.

You notified us that you need this leave beginning on_____ and that you
(date)

expect leave to continue until on or about_____.
(date)

Except as explained below, you have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period for the reasons listed above. Also, your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work, and you must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave. If you do not return to work following FMLA leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; or (2) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.

This is to inform you that (check appropriate boxes; explain where indicated):

1. You are ❑ eligible ❑ not eligible for leave under the FMLA.

2. The requested leave ❑ will ❑ will not be counted against your annual FMLA leave entitlement.

3. You ❑ will ❑ will not be required to furnish medical certification of a serious health condition. If required, you must furnish certification by_____ (insert date)(must be at least 15 days after you are notified of this requirement) or we may delay the commencement of your leave until the certification is submitted.

4. You may elect to substitute accrued paid leave for unpaid FMLA leave. We ❑ will ❑ will not require that you substitute accrued paid leave for unpaid FMLA leave. If paid leave will be used, the following conditions will apply: (Explain)

5. (a) You normally pay a portion of the premiums for your health insurance, these payments will continue during the period of FMLA leave. Arrangements for payment have been discussed with you and it is agreed that you will make premium payments as follows:

(b) You have a minimum 30-day grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

We ❑ will ❑ will not pay your share of health insurance premiums while you are on leave.

(c) We ❑ will ❑ will not do the same with other benefits (e.g., life insurance, disability insurance, etc.) while you are on FMLA leave. If we do pay your premiums for other benefits, when you return from leave you ❑ will ❑ will not be expected to reimburse us for the payments made on your behalf.

6. You ❑ will ❑ will not be required to present a fitness-for-duty certificate prior to being restored to employment. If such certification is required but not received, your return to work may be delayed until such certification is provided.

7. (a) You ❑ are ❑ are not a "key employee" as described in Sec. 825.218 of the FMLA regulations. If you are a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us.

(b) We ❑ have ❑ have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us. *(Explain (a) and/or (b) below See Sec. 825.219 of the FMLA regulations)*

8. While on leave, you ❑ will ❑ will not be required to furnish us with periodic report every_____ (indicate interval of periodic reports as appropriate for the particular leave situation) of your status and intent to return to work (see Sec. 825.309 of the FMLA regulations). If the circumstances of your leave change and you are able to return to work earlier than the date indicated on the reverse side of this form, you ❑ will ❑ will not be required to notify us at least two work days prior to the date you intend to report for work.

9. You ❑ will ❑ will not be required to furnish recertification relating to a serious health condition. (Explain below, if necessary, including the interval between certifications as prescribed in Sec. 825.308 of the FMLA regulations).

Your Rights

Under The

Family and Medical Leave Act of 1993

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for a covered employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles.

Reasons For Taking Leave:

Unpaid leave must be granted for any of the following reasons:

- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

At the employee's or employer's option, certain kinds of *paid* leave may be substituted for unpaid leave.

Advance Notice and Medical Certification:

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide thirty (30) days advance notice when the leave is "foreseeable."
- An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work.

Job Benefits and Protection:

- For the duration of FMLA leave, the employer must maintain the employee's health coverage under any "group health plan."
- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Unlawful Acts by Employers:

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA:
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement:

- The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.
- An eligible employee may bring a civil action against an employer for violations.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

For Additional Information:

Contact the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor.

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division
Washington, D.C. 20210

WH Publication 1420
June 1993

ARKANSAS DEPARTMENT OF FINANCE AND ADMINISTRATION
REQUEST FOR FAMILY AND MEDICAL LEAVE

(Please Print)

EMPLOYEE'S NAME _____

OFFICE _____ SECTION/UNIT _____

OFFICE PHONE _____

I am requesting to be placed on Family and Medical Leave for _____

(days, weeks, months) to begin on _____ and end

on _____.

I understand that Family and Medical Leave as federally mandated is unpaid leave. However, I may elect to substitute accrued paid leave for all or some portion of the leave.

I further understand that DFA may require a second opinion from a Health Care Provider at the expense of DFA.

I do _____ do not _____ give my permission for DFA's Health Care Provider to contact my Health Care Provider, for purposes of clarification and authenticity of the Medical Certification.

During a period of unpaid FMLA the agency/institution will continue paying the Employer matching portion of my Group Health Insurance Premium, provided I am a participant. I am responsible for paying the Employee's portion of the premium each pay period and that if I do not, my insurance may be cancelled after 30 days.

Please check the appropriate box below:

( ) I am requesting unpaid FMLA.

( ) I am requesting that my accrued leave (paid leave) be substituted for unpaid leave.

_____ _____
Employee's Signature Supervisor's Acknowledgement/Date

_____ _____
Date of Request Manager's Acknowledgement/Date

_____ _____
Employee's Social Security Number Administrator's Acknowledgement/Date

STATE OF ARKANSAS
Department of Finance & Administration
Family & Medical Leave Act of 1993

CERTIFICATE OF HEALTH CARE PROVIDER

1. Employee's Name	2. Patient's Name (if different from employee)

3. The attached sheet describes what is meant by a "**serious health condition**" under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

(1) ____ (2) ____ (3) ____ (4) ____ (5) ____ (6) ____, or None of the above ____

4. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

5.a. State the approximate **date** the condition commenced, and the probable **duration** of the condition (and also the probable duration of the patient's present **incapacity**[2] if different):

b. Will it be necessary for the employee to take work only **intermittently or to work on a less than full schedule** as a result of the condition (including for treatment described in Item 6 below)? _____

If yes, give the probable duration:

c. If the condition is a **chronic condition** (condition #4) or **pregnancy**, state whether the patient is presently incapacitated[2] and the likely duration and frequency of **episodes of incapacity**[2]:

6.a. If additional **treatments** will be required for the condition, provide an estimate of the probable number of such treatments:

If the patient will be absent from work or other daily activities because of **treatment** on an **intermittent** or **part-time** basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

b. If any of these treatments will be provided by **another provider of health services** (e.g., physical therapist), please state the nature of the treatments:

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[1] Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

[2] "**Incapacity**," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

c. **If a regimen of continuing treatment** by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

7.a. If medical leave is required for the employee's **absence from work** because of the **employee's own condition** (including absences due to pregnancy or a chronic condition), is the employee **unable to perform work** of any kind?_____

b. If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (the employee or the employer should supply you with information about the essential job functions)?_____ If yes, please list the essential functions the employee is unable to perform:

c. If neither a. nor b. applies, is it necessary for the employee to be **absent from work for treatment?**

_____

8.a. If leave is required to **care for a family member** of the employee with a serious health condition, **does the patient require assistance** for basic medical or personal needs or safety, or for transportation?_____

b. If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery?_____

c. If the patient will need care only **intermittently** or on a part-time basis, please indicate the probable **duration** of this need:

_____
(Date)

_____ _____
(Signature of Health Care Provider) (Type of Practice)

_____ _____
(Address) (Telephone number)

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

_____ _____
(Employee Signature) (Date)

A **"Serious Health Condition"** means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

Inpatient care (*i.e.*, an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity[2] or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

(a) A period of incapacity[2] of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity[2] relating to the same condition), that also involves:

(1) **Treatment[3] two or more times** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (*e.g.*, physical therapist) under orders of, or on referral by, a health care provider; *or*

(2) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment**[4] under the supervision of the health care provider.

3. Pregnancy

Any period of incapacity due to **pregnancy,** or for **prenatal care.**

4. Chronic Conditions Requiring Treatments

A **chronic condition** which:

(1) Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

(2) Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and

(3) May cause **episodic** rather than a continuing period of incapacity[2] (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

A period of **incapacity[2]** which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under the continuing supervision of, but need not be receiving active treatment by, a health care provider.** Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

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3 Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

4 A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive **multiple treatments** (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for **restorative surgery** after an accident or other injury, **or** for a condition that **would likely result in a period of incapacity[2] of more than three consecutive calendar days in the absence of medical intervention or treatment,** such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).